AMENDED IN SENATE JUNE 1, 2016

AMENDED IN SENATE MARCH 30, 2016

SENATE BILL No. 1135

Introduced by Senator Monning

February 18, 2016

An act ~~to amend Section 1368.02 of, and~~ to add Section 1367.031 ~~to,~~ *to* the Health and Safety Code, ~~to add Sections 10133.53 and 10133.662 to the Insurance Code, and to add Section 14450.1 to the Welfare and Institutions Code,~~ *and to add Section 10133.53 to the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1135, as amended, Monning. Health care coverage: notice of timely access to care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires each prepaid health plan to establish a grievance procedure under which enrollees may submit their grievances.

This bill would require a health care service plan contract or a health insurance policy that is issued, renewed, or amended on or after January 1, 2017, to provide information to enrollees and insureds regarding the standards for timely access to health care services and other specified health care access information, including information related to receipt of interpreter services in a timely manner, no less than annually, and would make these provisions applicable to Medi-Cal managed care plans. ~~The bill would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to provide an enrollee or an insured with information regarding consumer assistance provided by the licensing agency, as specified.~~ The bill would also require a health care service plan or a health insurer to provide a contracting health care provider with specified information relating to the provision of referrals or health care services in a timely manner.

Because a willful violation of the bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.031 is added to the Health and Safety Code, to read:

1367.031. (a) A health care service plan contract that is issued, renewed, or amended on or after January 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice

of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. The information shall be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) In the same manner and place that notice of language assistance programs is provided pursuant to Section 1367.04 and the regulations adopted thereunder.

(3) In a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

(d) A health care service plan shall also provide the information required by this section to contracting providers on no less than an annual basis, and shall additionally provide a contracting provider with the following information:

"If one of your patients is unable to obtain a timely referral, either you or your patient may call the health care service plan or the Department of Managed Health Care Help Center at 1-888-HMO-2219 to obtain help.

California law requires a health care service plan to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition, consistent with good professional practice. If an appointment is delayed or extended, the referring or treating health care professional shall note in the relevant record that a longer waiting time will not have a detrimental effect on the health of the enrollee.

It is the obligation of the health care service plan to have sufficient numbers of contracted providers to maintain compliance

with timely access to care for enrollees. If a contracting provider is unable to provide care in a timely manner consistent with the requirements for timely access to care, the health care service plan shall have in place policies and procedures to ensure that the enrollee shall receive timely access to care."

(e) This section shall apply to plans with Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

~~SEC. 2. Section 1368.02 of the Health and Safety Code is amended to read:~~

~~1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.~~

~~(b) (1) Every health care service plan shall include the department's toll-free telephone number and Internet Web site address on the card presented by enrollees to providers as proof of coverage. The department's toll-free telephone number and Internet Web site address shall be displayed immediately below the toll-free telephone number for the health care service plan. The health care service plan may include the following statement on the card:~~

~~"Please contact us first regarding any complaint. If you wish to complain directly to the government agency that licenses this health plan, please call 1-888-HMO-2219."~~

~~(2) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site~~

~~address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:~~

~~"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."~~

~~SEC. 3.~~

SEC. 2. Section 10133.53 is added to the Insurance Code, to read:

10133.53. (a) A policy of health insurance that is issued, renewed, or amended on or after January 1, 2017, shall provide information to an insured regarding the standards for timely access to care adopted pursuant to Section 10133.5 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health insurer for a policy of health insurance, as defined in subdivision (b) of Section 106, that provides or arranges for hospital or physician services at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established pursuant to Section 10133.5 to insureds and contracting providers. The information shall also include notice

of the availability of interpreter services at the time of the appointment pursuant to Section 10133.8. A health insurer for a policy of health insurance may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(c) The information required to be provided pursuant to this section shall be provided to an insured with individual coverage upon initial enrollment and annually thereafter upon renewal, and to insureds and group ~~policy holders~~ *policyholders* with group coverage upon initial enrollment and annually thereafter upon renewal. The information shall be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) In the same manner and place that notice of language assistance programs is provided pursuant to Section 10133.8 and the regulations adopted thereunder.

(3) In a separate section of the provider directory published and maintained by the insurer pursuant to Section 10133.15. The separate section shall be titled "Timely Access to Care."

(4) On the Internet Web site published and maintained by the insurer, in a manner that allows insureds and prospective insureds to easily locate the information.

(d) A health insurer shall also provide the information required by this section to contracting providers on no less than an annual basis, and shall additionally provide a contracting provider with the following information:

"If one of your patients is unable to obtain a timely referral, either you or your patient may call the health insurer or the Department of Insurance at 1-800-927-4357 to obtain help.

California law requires a health insurer to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the insured's condition, consistent with good professional practice. If an appointment is delayed or extended, the referring or treating health care professional shall note in the relevant record that a longer waiting time will not have a detrimental effect on the health of the insured.

It is the obligation of the health insurer to have sufficient numbers of contracted providers to maintain compliance with

timely access to care for insureds. If a contracting provider is unable to provide care in a timely manner consistent with the requirements for timely access to care, the health insurer shall have in place policies and procedures to ensure that the insured shall receive timely access to care."

~~SEC. 4. Section 10133.662 is added to the Insurance Code, to read:~~

~~10133.662. Every health insurer shall include the department's toll-free telephone number and Internet Web site address on the card presented by insureds to providers as proof of coverage. The department's toll-free telephone number and Internet Web site address shall be displayed immediately below the toll-free telephone number for the insurer. The insurer may include the following statement on the card:~~

~~"Please contact us first regarding any complaint. If you wish to complain directly to the government agency that licenses this insurer, please call 1-800-927-4357."~~

~~SEC. 5. Section 14450.1 is added to the Welfare and Institutions Code, to read:~~

~~14450.1. Medi-Cal managed care plans shall include on the card presented by enrollees to providers as proof of coverage the toll-free telephone number for the department's Medi-Cal Managed Care Office of the Ombudsman. A plan may omit this information if it complies with paragraph (1) of subdivision (b) of Section 1368.02 of the Health and Safety Code.~~

~~SEC. 6.~~

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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